
Hearing Officer's recommendations. If a party still feels aggrieved at this point, judicial review is available to contest actions of the department and the rate set.

IX Audit Function:

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect the prospective payment rates are adopted by the Department and incorporated into future prospective rate calculations. This means that even though an audit is not completed before a subsequent year has passed and retroactive recoupment from the facility will not take place, the results of the audit will be incorporated into the rate calculations relating to future prospective periods as applicable.

X Inappropriate Level of Care:

Payment for hospital patients receiving service at an inappropriate level of care under conditions similar to those described in Section 1861(v)(1)(G) of the Social Security Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with Section 1861(v)(1)(G). The payment rate will be the average statewide rate for swing bed days. The state uses the same methodology for SNF services and ICF services, and does not differentiate between the different types of services. The swing bed rate is a composite rate weighted by patient days and is a summation of each facility's payment rate for the preceding calendar year multiplied by patient days of each facility and then divided by the total patient days of all SNF/ICF facilities. The swing bed rate is determined and approved by the Department prior to the beginning of the calendar year and is based, where applicable, on estimated data.

The state continues the policy of paying the lower rates to inpatient hospitals when the patient receives care at either the skilled or intermediate level nursing services with no exceptions.

XI Hospitals Serving A Disproportionate Share of Low Income Patients:

Hospitals serving a disproportionate number of patients with special needs will receive a payment adjustment based on the following criteria:

- (1) Determination of Eligibility. (a) The hospital's Alaska Medicaid inpatient utilization rate, (as described in Section 1923(b)(2)), is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State of Alaska, (the "mean" of Medicaid inpatient utilization rates for all hospitals in the state is the fraction, expressed as a percentage, of which the numerator is the total number of inpatient days for Medicaid-eligible patients for all hospitals in the state and the denominator is the

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total number of inpatient days for all hospitals in this state) or (b) the hospital's Alaska low income utilization rate, (as described in Section 1923(b)(3)), exceeds 25 percent. To determine eligibility under (1)(a) and (1)(b), data from the hospital's qualifying year as described in this section at (12) will be used.

For purposes of (1)(a), the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the State plan (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days. The standard deviation of Medicaid inpatient utilization, will be calculated by June 1 of each year for all facilities.

For purposes of (1)(b), the "low income utilization rate" is calculated as follows: the total Medicaid revenues paid to the hospital in the hospital's qualifying year (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), plus the amount of cash subsidies for patient services received directly from Alaska state and local governments in the hospital's qualifying year, divided by the total amount of revenues of the hospital (including the amount of such cash subsidies) for the hospital's qualifying year; plus the hospital's charges for inpatient hospital services attributable to charity care for the hospital's qualifying year less the portion of any cash subsidies for patient services received directly from Alaska state and local governments attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the same period. For State facilities which do not have a charge structure, the hospital's charges for charity care are the cash subsidies received from Alaska state and local governments by the facility. The "low income utilization rate" will be calculated annually upon receipt from the facilities, relevant information necessary in determining the utilization rate.

As an example of determining eligibility, if the Alaska Medicaid inpatient utilization rate at one standard deviation above the mean Alaska Medicaid inpatient utilization for hospitals in Alaska is 32 percent, a facility with a Medicaid inpatient utilization of 32 percent or greater will qualify for a disproportionate share payment adjustment under (1) (a).

Alternatively, if another facility has a Medicaid inpatient utilization of 30 percent, it would not qualify for a disproportionate share payment adjustment under (1)(a), but could qualify under (1)(b) if its low income utilization rate exceeds 25 percent.

In addition, in order to qualify as a DSH, a hospital must have a Medicaid inpatient utilization rate in its qualifying year of a minimum of one percent.

- (2) Payment Adjustment. (a) For those hospitals that qualify for disproportionate share payment adjustments under (1)(a), the minimum payment will be one percent of allowable charges. This minimum payment reflects a provider whose Alaska Medicaid inpatient utilization is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State of Alaska. The disproportionate share payment adjustment will increase proportionately to the increase in Medicaid inpatient utilization above the minimum level by one of two methods elected by the facility: (i) an additional one percent of charges for each percentage point above one standard deviation above the mean Alaska Medicaid inpatient utilization rate; or (ii) an additional payment equal to 1.60% of the hospital's qualifying year Alaska state and local government cash subsidies for each percentage point above one standard deviation above the mean Alaska Medicaid qualifying year inpatient utilization rate.

For example, if the Medicaid inpatient utilization at one standard deviation above the state-wide mean is 32 percent and the hospital's utilization is 33 percent, the hospital may choose a disproportionate share payment adjustment to that hospital's Medicaid rate with a minimum payment of 1 percent of allowable charges and a choice of either an additional payment of: (i) 1 percent of allowable charges (for a total disproportionate share payment adjustment of 2 percent of allowable charges); or (ii) 1.60% times the Alaska state and local government cash subsidies paid to the hospital during the hospital's most recently completed qualifying year. If the hospital's Medicaid inpatient utilization is 34 percent, the facility may choose for its disproportionate share payment one of two methods to calculate its additional payment: (i) 3 percent of allowable charges; or (ii) 1 percent of allowable charges plus 3.2% of the Alaska state and local government cash subsidies paid to the hospital during the hospital's most recently completed qualifying year. The payment adjustment is subject to a facility specific limit as described in this section at (11).

(b) For those hospitals that qualify for disproportionate share payment adjustments under (1)(b) but do not qualify under (1)(a), the payment will be a minimum of one percent of allowable charges. This minimum payment reflects a provider whose low income utilization rate is at least 25 percent. The disproportionate share payment will increase proportionately to the increase in the low income utilization rate above the minimum level by one of two methods elected by the facility: (i) an additional percentage by which the hospital's low-income utilization rate exceeds 25%; or (ii) an additional payment equal to 1.60%

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of the hospital's state and local government cash subsidies for each percentage point above 25%.

For example, if the hospital's low income utilization rate is 26 percent, the hospital may choose a disproportionate share payment adjustment to that hospital's Medicaid rate with a minimum of 1 percent of allowable charges and a choice of either an additional payment of: (i) 1 percent of allowable charges (for a total disproportionate share payment adjustment of 2 percent of allowable charges); or (ii) 1.60% times the state and local government cash subsidies paid to the hospital during the hospital's most recently completed fiscal year. If the hospital's low income utilization rate is 27 percent, its total disproportionate share payment will be the greater of: (i) 3 percent of allowable charges; or (ii) 1 percent of allowable charges plus 3.2% of the state and local government cash subsidies paid to the hospital during the hospital's qualifying year. This provision is intended to take into account the situation of public institutions that furnish services free of charge or at nominal charges. The payment adjustment is subject to a facility specific limit as described in this section at (11).

- (3) Other Requirements. All hospitals qualifying for the disproportionate share must meet the criteria of having two obstetricians providing obstetrical services to Medicaid patients or in rural areas must have two physicians providing non emergency obstetrical services to Medicaid patients. Hospitals that do not offer obstetrical services as of December 22, 1987 will be exempt from this requirement.
- (4) A qualifying hospital will receive an additional disproportionate share payment for exceptionally high costs or exceptionally long-stays for children under age six. Exceptionally high costs are those exceeding 150 percent of the mean costs per admission in the facility qualifying year for children under age six. Similarly, exceptionally long-stays are those exceeding 150 percent of the mean days per admission in the facility for children under age six. The additional disproportionate share payment will be 100 percent of the hospitals disproportionate share rate determined in (2) (a) or (2)(b), subject to the facility-specific limit explained in (10) of this section. This payment will be made only if the facility provides documentation satisfactory to the department that these criteria have been met.
- (5) Out-of-State hospitals providing inpatient services to Alaska Medicaid recipients and who have a disproportionate share of Medicaid patients may request to receive a payment adjustment relative to the methods and standards in (2)(a) and (2)(b) above. If an out-of-State hospital does request a DSH adjustment, they must supply all necessary data in order for the State to complete the calculations.

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- (6) The percentage of disproportionate share payment is not subject to the limitations of 100% of charges.
- (7) The total disproportionate share payments to all hospitals in the aggregate will be limited to the Federal disproportionate share cap established for the State of Alaska. A comparison of the Federal cap to the State's estimated total disproportionate share payments for the federal fiscal year will occur before any payments are distributed to qualifying hospitals.
- (8) If the State's estimated total disproportionate share and/or IMD payments exceed the Federal cap for those payments, the State will proportionately reduce the disproportionate share and/or IMD payments to be made to facilities in the state.
- (9) The State will recalculate and reallocate the disproportionate share eligibility and payments for all hospitals and will recoup payments from all hospitals on a prorated basis if the disproportionate share eligibility and payment for any hospital must be recalculated as a result of a final commissioner's decision in an administrative appeal or of a court decision that would cause the total disproportionate share payments to exceed the federal allotment and/or the IMD cap for the federal fiscal year in which the payment rate was in effect.
- (10) Facility Specific Limit Hospitals' DSH payments are limited to: The Cost of Services to Medicaid patients less the amount paid by the State under the non-DSH payment provisions of the State Plan; plus the Cost of Services to Uninsured Patients less any cash payments made by them or on their behalf for those services.

An Uninsured Patient is defined as an individual who's costs are not met because they have no insurance or other resources.

Cost of Services is total allowable costs of the hospital as defined in the State Plan divided by total inpatient days of the hospital times Uninsured Inpatient Days or Medicaid Inpatient Days as applicable.

- (11) This section outlines methods and standards for calculating a disproportionate share adjustment to each prospective payment year beginning during the period this plan is effective. For purposes of making the DSH calculations in this section:
- a. a "Qualifying" year means a hospital's base year for its prospective rate year beginning immediately after the qualifying date of June 1 of each year. The base year is the hospital's fiscal year ending 24 months before the prospective rate year.

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- b. "inpatient days" means patient days at a licensed hospital that are calculated to include: injured, disabled or sick; substance abuse patients hospitalized for substance abuse detoxification; swing bed patients whose hospital level of care is reduced to nursing facility level without a physical move of the patient; patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled or sick persons; patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness; and newborn infants in hospital nurseries.
- c. Not to include Medicaid covered and non-covered patient days related to the treatment of patients: at licensed nursing facilities; in a residential treatment bed; on leave of absence from a hospital beginning with the day the patient begins a leave of absence; who are in a hospital for observation to determine the need for inpatient admission; or who receive services at a hospital during the day but are not housed there at night.
- d. "institution for mental disease" or "IMD" means a hospital of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services; whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not the facility is licensed as such.

XII. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate setting methodology. This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;
2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

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3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;
 4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;
 5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;
 6. an analysis of community needs for the service on which the exception request is based;
 7. a detailed analysis of the options of the facility if the exception is denied;
 8. a plan for future action to respond to the problem; and
 9. any other information requested by the deputy commissioner to evaluate the request.

The deputy commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The deputy commissioner may increase the rate, by all or part of the facility's request if the deputy commissioner finds by clear and convincing evidence that the rate established under section IV. and V. of Attachment 4.19-A does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;
2. the assessment of continued need for this facility's services in the community;
3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;
4. the recommendations, if any, from the Commission;

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5. the availability of other resources available to the facility to respond to the crisis;
6. whether the relief should have been obtained under the existing rate methodology;
7. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The deputy commissioner will impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;
2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;
3. the facility providing documentation as specified of the continued need for the exception; or
4. a maximum amount of exceptional relief to be granted to the facility under this section.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the deputy commissioner concerning exceptional relief may request an administrative hearing to the commissioner of the department.

XIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

XIV. Proportionate Share Incentive Payments for Public Hospitals.

1. The department recognizes that many public hospitals provide basic support for community and regional health care to clients who would otherwise be unable to readily access needed inpatient hospital service. To ensure continued access, proportionate share incentive payments (Hospital Pro-Share payments) are provided to in-State public hospitals. At least annually the department will advise all such hospitals to formally request participation in the Hospital Pro-Share payment program.

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2. A public hospital is one that:
 - is owned by a government entity that qualifies as a “unit of government” under 42 U.S.C. 1396b(w)(6)(A), and
 - is governed by a Board of Directors who serve under authority of a government entity, and
 - has board meetings that satisfy the Alaska law about Open Meetings of Governmental Bodies AS 44.062.310 – AS 44.62.312, and
 - is operated directly by a government entity, or is operated under a management contract that rests responsibility and authority for increase or decrease in net assets and net revenues with a government entity.
3. Hospital Pro-Share payments shall be paid at least annually during each Federal Fiscal Year based on legislatively approved appropriations and the State’s determination of the amount of funding available for the Hospital Pro-Share payments. The State recognizes that occupancy is the key measure in determining the payment for each participating hospital. Specifically, a hospital with a low occupancy level tends to be more fiscally vulnerable compared to a hospital with a high occupancy level. Each participating hospital will be assigned an occupancy weight as follows:

<u>Occupancy Level</u>	<u>Occupancy Weight</u>
40 percent or more	1.00
30 – 39 percent	1.05
20 – 29 percent	1.10
10 – 19 percent	1.15
less than 10 percent	1.20

The occupancy level used to determine a hospital’s occupancy weight will be the percent that results from dividing the total number of patient days by the total number of available bed days disclosed in the Medicare cost report for the hospital’s fiscal year ending 24 months before the payment.

A payment per occupancy weight is determined by dividing total available funds by the sum of the occupancy weight assigned to each participating hospital. The resulting amount is then applied to the participating hospital’s assigned occupancy weight. Hospital Pro-Share payments will be subject to the Medicare upper limit requirement at 42 CFR 447.272 and will be made only after the State’s analysis assures that the aggregate Medicare upper limit will not be exceeded.

4. Hospital Pro-Share payments will not be subject to settlement (payment at the lower of costs or rate), or to state law governing payment rates AS 47.07.070 or regulations in 7 AAC 43.670 – 7 AAC 43.709.

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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Medicaid Rate Advisory Commission
Acute Care Upper Limit Calculations
2001 Acute Care Upper Limit Total-Jan 1 thru June 30, 2001
(with 1/12/2001 final rule change)

07/27/01

State Government Owned

Alaska Psychiatric Hospital	\$113,856	
TOTAL Under/(Over) Upper Limit		\$113,856

Non-State Government Owned

Bartlett	\$392,428	
Central Peninsula	\$37,057	
Cordova	\$67,378	
Petersburg	\$35,641	
Seward	\$18,561	
Sitka	\$37,599	
South Peninsula	(\$4,512)	
Valdez	(\$82,237)	
Wrangell	\$49,117	
Subtotal		\$551,033

Disproportionate Share (Medicare)

Central Peninsula	186,585	
		\$186,585
		\$737,618
		x 150%
42 CFR 447.272(c) Exceptions TOTAL Under/(Over) Upper Limit		\$1,106,426

Privately-Owned

Alaska Regional	(\$640,775)	
Charter North	(\$139,085)	
Fairbanks	\$1,650,728	
Ketchikan	\$287,955	
Kodiak	(\$84,454)	
Norton Sound	\$2,099	
Providence	\$5,335,244	
Providence (NICU)	\$5,675,261	
Valley	(\$1,380,472)	
Subtotal		\$10,706,500

Disproportionate Share (Medicare)

Alaska Regional	1,197,108	
Norton Sound	38,817	
Providence	2,918,037	
		4,153,962

Graduate Medical Education(GME)(Medicare)

Providence	827,077	
		827,077

TOTAL Under/(Over) Upper Limit	\$15,687,539
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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Medicaid Rate Advisory Commission
Acute Care Upper Limit Calculations
2001 TEFRA Limit - Jan 1 thru June 30, 2001
(with 1/12/2001 final rule change)

7/27/01

State Government Owned

Alaska Psychiatric Hospital	\$621,924	
Subtotal		<u>\$621,924</u>
Less Medical Assistance Payments		508,068
Total Under/(Over) UL		<u>113,856</u>

Non-State Government Owned

Bartlett	\$1,162,490	
Central Peninsula	1,050,536	
Cordova	111,533	
Petersburg	58,178	
Seward	38,041	
Sitka	110,319	
South Peninsula	535,243	
Valdez	7,842	
Wrangell	103,659	
Subtotal		<u>\$3,177,842</u>

Disproportionate Share (Medicare)

Central Peninsula	186,585	
		<u>\$186,585</u>
		<u>\$3,364,427</u>
		x 150%
42 CFR 447.272(c) Exceptions Subtotal		<u>\$5,046,641</u>

Less Medical Assistance Payments	3,940,215
Total Under/(Over) UL	<u>1,106,426</u>

Privately-Owned

Alaska Regional	4,604,191	
Charter North	2,648,012	
Fairbanks	3,848,675	
Ketchikan	991,244	
Kodiak	647,554	
Norton Sound	213,411	
Providence	14,019,018	
Providence (NICU)	9,208,358	
Valley	1,109,701	
Subtotal		<u>\$37,290,165</u>

Disproportionate Share (Medicare)

Alaska Regional	1,197,108	
Norton Sound	38,817	
Providence	2,918,037	
		<u>4,153,962</u>

Graduate Medical Education

Providence	827,077	
		<u>827,077</u>
Subtotal		<u>\$42,271,204</u>

Less Medical Assistance Payments	26,583,665
Total Under/(Over) UL	<u>15,687,539</u>